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ORIGINAL ARTICLE

Transitional discharge model for community mental health integration: A focused ethnographic study of clients' perspectives

***Cheryl Forchuk*,[1,2] *Sebastian Gyamfi*,[1,2] *Mary-Lou Martin*,[3,4] *Deborah Corring*,[6] *Rani Srivastava*[5] *and Boniface Harerimana*[1,2]**

[1]*Lawson Health Research Institute,* [2]*Arthur Labatt School of Nursing, Western University,* [3]*School of Nursing, McMaster University, Hamilton,* [4]*St. Joseph's Healthcare, Hamilton,* [5]*Centre for Addiction and Mental Health, and* [6]*Division of Psychiatry, Schulich School of Medicine and Dentistry, Western University, London, Ontario, Canada*

ABSTRACT: *Clients' perceptions of continuous support during the transition from hospital to the community have been understudied. The present study evaluated clients' perceptions of the benefits and potential adjustments to the implementation of a transitional discharge model (TDM), an intervention for community integration of clients with mental health issues. A focused ethnography methodology was used to investigate the effectiveness of the TDM. Data were collected using two sets of focus groups which involved 87 clients with mental illness seeking care from nine hospitals across the Province of Ontario, Canada. One focus group was conducted at six months and another at the one-year time point of the study. Data analysis followed a four-step ethnographic approach proposed by Leininger (1985) for thematic analysis in qualitative research. Four main themes emerged: (i) clients' perceived benefits of the TDM. These came in the form of reassurance about transitioning from hospitalization to community, reduced feelings of isolation, and enhanced continuity of care and recovery, (ii) TDM for community integration; clients believed that the intervention offered suitable friendships, was a tool for social connectedness, and helped to reduce stigma, (iii) encountered challenges, which included issues with trust, perceiving peer supporters as intruders, issues with communication, and initial fears about discharge and (4) suggestions for improving the TDM, such as, more in-person interactions, formalizing the TDM and raising awareness about community resources. The TDM implementation may facilitate the transition from hospital to the community by offering social support that enhances recovery.*

KEY WORDS: *clients, community integration, focused ethnography, mental illness, transition discharge model.*

Correspondence: Cheryl Forchuk, Beryl and Richard Ivey Research Chair in Aging, Mental Health, Rehabilitation and Recovery, Mental Health Nursing Research Alliance, Lawson Health Research Institute, Parkwood Institute Mental Health Care Building, 550 Wellington Road, Suite B3-110, London, P.O. Box 5777, STN B, N6A 4V2. Email: cforchuk@uwo.ca

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Cheryl Forchuk, PhD, Beryl and Richard Ivey Research Chair in Aging.
Sebastian Gyamfi, MPhil, PhD(c), Graduate Research Assistant.
Mary-Lou Martin, MScN Med, Associate Clinical Professor.
Deborah Corring, PhD, Scientist.
Rani Srivastava, PhD, Chief Nursing.
Boniface Harerimana, PhD, PostGraduate Research Assistant.

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BACKGROUND

Over the last two decades, an emphasis has been put on the integration of mental health care into community-based health services (Barker, 2014; Brophy, & Morris, 2014; Neumann, Schroeder, & Voss, 1989). This shift of focus in mental healthcare provision has sparked a need for new ways of addressing subsequent clinical challenges. New clinical challenges include the pressure of reducing inpatient beds (Krupinski, 1995; Priebe *et al*. 2005) as well as the length of stay for admitted clients with severe mental illness and shortened periods between discharge and readmissions in hospitals (Pratt, Gill, Barrett, & Roberts, 2014). The focus shift has also been alleged to cause early discharge without sufficient time for planning clients' community reintegration (Niimura, Tanoue, & Nakanishi, 2016; Pedersen & Kolstad, 2009). Insufficient time for planning community reintegration has contributed to increased risks for adverse health outcomes, such as frequent readmissions and long-term homelessness (Forchuk *et al*. 2008; Montgomery, Metraux, & Culhane, 2013; Pratt *et al*. 2014). These adverse health outcomes may be associated with the challenges clients face during the post-discharge period. In post-discharge, clients with mental illness face four main challenges including the following: (i) difficulties regarding the management of their lifestyles following discharge; (ii) resistance to seeking assistance for symptoms or side effects because clients think that this will not lead to solutions; (iii) conflicts with family members with whom they lived due to their limited abilities to fulfil their roles; and (iv) difficulty of seeking outpatient care as a result of dissatisfaction with multiple changes of healthcare providers with whom they had already established relationships (Niimura *et al*. 2016).

In the post-discharge period, other factors may contribute to adverse health outcomes and difficulties in clients' integration into community-based mental health services. A systematic review by Kreyenbuhl, Nossel and Dixon (2009) demonstrated that clients suffering from long-term mental illness, such as schizophrenia, disengage from treatment due to their perceptions of mental health care. Such perceptions include clients' views about the necessity of treatment, the effects of treatment on client needs and their feelings of not being involved in the process of care (Kreyenbuhl *et al*. 2009). Evidence has linked unsuccessful community mental health integration to factors that include the following: (i) absence of community awareness of mental health; (ii) limited logistic and human resources; and (iii) insufficient involvement of organizations and community residing groups of individuals (Neumann *et al*. 1989). As such, scholars developed and evaluated deferent initiatives aimed at improving community mental health integration of clients during the post-discharge period. Recent quantitative findings about the TDM implementation (Forchuk, *et al*. 2019; Lam, *et al*. 2020) reveal that not only does the intervention reduce hospital readmissions, length of stay and hospitals spending, but also contributes to recovery by keeping clients out of hospital and aiding in their community integration through peer support systems.

Previous interventions for Community Integration of Clients with Mental Illness

Various studies have developed and tested interventions for improving community integration of clients with mental illness. In the later 1990s, the transitional discharge model (TDM), a comprehensive community integration programme, was developed and initially tested in Ontario, Canada by Forchuk, Jewell, Schofield, Sircelj and Valledor (1998). Client recipients of mental healthcare through the TDM study were provided with a safety net as they transitioned from hospital discharge to community integration (Forchuk *et al*. 1998). This safety net consisted of offering clients peer supporters as well as hospital staff throughout the transition. Peer supporters are mental healthcare consumers, who had already successfully transitioned to the community and are identified in partnership with community consumer survivors' initiatives (Forchuk *et al*. 2005; Forchuk *et al*. 1998). Clients and their peer supporters met regularly; these encounters served as a forum to pass on successful experiences and encouragement. The implementation of TDM requires each hospital unit to have a peer support coordinator, whose role is to facilitate the allocation of peer supporters to client participants.

Through the TDM, clients' safety net is also ensured through continuous support from hospital staff, 'bridging staff support', allocated to each client. The bridging staff support is a healthcare provider with whom clients have established therapeutic relationships. The role of bridging staff support is to keep contact with the client participant following discharge until the client has an established therapeutic relationship with a community care provider (Forchuk *et al*. 2005; Forchuk, *et al*. 1998). The bridging staff's contact with clients encompasses one-on-one communication, either in-person or via telephone and accompaniment to initial

appointments with community care providers (Forchuk *et al*. 1998). Apart from hospital partnering/coordinating with community-based consumer survivor' initiatives for the provision of peer supporters, supplementary leadership and support may be provided by a Site Lead, a person at the hospital who is responsible for the implementation of the TDM. Site Leads have to offer needed extra supports for the implementation of the TDM; which include backfilling, paperwork and accompaniment to initial community visits.

In addition to the TDM, other interventions that focus on continuity of mental health care in post-discharge from psychiatric treatment have revealed positive results. A critical time intervention offered to clients with severe mental illness in a time-limited care coordination emphasizes the provision of support and continuous care. Transitional interventions have demonstrated benefits in preventing adverse health outcomes among clients' beneficiaries, especially in their post-discharge period (Herman, 2014; Herman *et al*. 2011; Jones *et al*. 2003). A review of the literature suggested that involving peer support in client community integration, after discharge from the hospital, has the potential to reduce readmissions to the hospital (Repper & Carter, 2011). In light of the above-noted evidence, we initiated an implementation of the TDM (Forchuk *et al*. 1998) in nine hospitals in Ontario Canada. We believe that an effective intervention for addressing challenges associated with the post-discharge period such as the TDM may still require planning for efficient client community integration. Again, we believe that planning for client community integration may start as soon as clients are admitted into the hospital by providing support to them as they transition from inpatient to community mental health care.

AIM

The present study aimed to evaluate clients' perceptions of benefits and potential adjustments to the implementation of a transitional discharge model (TDM), an intervention that offers clients with psychiatric illness continuous support during the transition from the hospital to the community.

METHODS

Design and sampling

The mixed-methods study design used participatory action research (PAR) approach to investigate the perceived benefits and required adjustments for effective TDM implementation among persons with mental illness. The present paper reports on a qualitative component that was conducted with focused ethnography methodology. The methodology was deemed fit because it provides pragmatic options for investigating phenomena that enable, obstruct or sustain healthcare practices (Walsh, 2009) among persons with experiences in a relatively shorter period than that required for conventional ethnography (Higginbottom, Boadu, & Pillay, 2013; Knoblauch, 2005). In keeping with PAR tenets, such as empowerment (Baum, MacDougall, & Smith, 2006; Zhu, 2019) a descriptive approach was used to make the research participants voice heard. This study involved nine hospitals across the Province of Ontario, Canada, over two years. Data were collected during focus groups that included 87 client participants. Client participants were introduced to the TDM intervention by their healthcare providers shortly upon admission to inpatient mental health care. The enrolment of client participants to the TDM consisted of healthcare providers assessing their client's needs for peer support and research assistants checking to ensure that they met the inclusion criteria. Clients were enrolled if they were: (i) admitted to hospital for mental health care; (ii) able to understand English to the extent necessary to participate; (iii) competent to give their informed consent; and (iv) discharged from a unit participating in the study. In collaboration with participating hospitals, enrolled clients received peer support in the community through in-house peer support workers, paid community peer support workers, community peer support volunteers or hospital volunteer services. They also had continued involvement of hospital staff until a therapeutic relationship was established with a community care provider. Before the enrolment of participants, the study was approved by the Western University Human Science Research Ethics Board (UWO REB 103435). Data collection was preceded by obtaining participants' informed consent for participating in the study.

Overall, 87 clients participated in two sets of focus groups. The average age of clients for both focus groups was 44.2 years. Males and females were equally represented in both groups. The majority of clients were of Caucasian descent (62.0%), and more than half had completed community college or university (60.0%), with less having completed high school as their highest level of education (27.6%). Among participants, psychiatric diagnoses were consistent across both focus groups: mood disorders 54.3%; anxiety disorders

38.3%; and schizophrenia or schizoaffective disorders 25.9%.

Data collection procedures

Data collection used two sets of focus groups, which occurred at six (6) and twelve (12) months into the TDM implementation. Focus groups took place at each of the participating hospitals and were one to two hours long. Focus groups were done at each time period across all nine participating hospital sites. All focus groups were audio-recorded and transcribed verbatim. Note-takers collected the additional data on group dynamics, context and non-verbal information that was integrated into the focus group transcripts.

Data analysis approach

The process of data analysis used a four-step ethnographic approach developed by Leininger (1985). During focus group discussions, the observations that the two note-takers documented on non-verbal cues as well as group dynamics in relation to the general context of the discussions were transcribed and integrated into the focus group transcripts. After extensive reading of focus group transcripts, two members of the research team analysed data and identified distinct descriptors from each site data separately. Subsequently, descriptors enabled the researchers to evaluate similarities and differences across the focus group transcripts. Descriptors, such as what worked well, what did not work well and suggestions for improvement, were used as a guide to identify preliminary codes and recurrent themes. Recurrent themes were analysed for their meaning in relation to the context of participants from which data were collected. Themes were aggregated to form distinct concepts (major themes). Co-researchers individually evaluated and commented on the preliminary results, and then, all comments were aggregated and integrated into the final results (Graneheim, & Lundman, 2004) to enhance the credibility of findings.

RESULTS

Clients' perceived benefits of the TDM intervention

Clients who participated in the TDM reported that the intervention promoted their health outcomes. The intervention contributed to clients' reassurance about transitioning from hospitalization to community, reduced feelings of isolation, and enhanced continuity of care and recovery.

Reassurance about transitioning to community

Clients who were involved in the TDM formed beneficial bonds with peer supporters through which they were able to exchange experiences and get necessary emotional support. Through the exchange between clients and their peer supporters, clients felt reassured of a smooth transition from the hospital to their community; and as a result, they were able to overcome anxiety associated with discharge as well as shorten their hospital stay. One client described the experience of their involvement in the TDM as follows:

> 'I have been hospitalised before. This time around, I had such a short stay [in hospital] ... it was like very scary to see my discharge date. This is my first month after discharge. The fear and anxiety just went out the door. Because she [Peer] basically said no worries, we'll get everything set up for you ....to have that reassurance... and she really followed through and this has, you know, I can't believe that it's worked out so well...it's worked out so well'.

Reduced feelings of isolation

Mental health services that implement the TDM may facilitate clients overcoming their previous feelings of isolation, which are commonplace for clients with mental illness. One of the clients participating in the intervention underlined this benefit using the statement below:

> 'Going from having a really big social network in the workforce, to being off work on long term was very devastating and very isolating, so again I think that's why I struggled more (with previous discharges) ...less social isolation, you know, getting out of the house, actually doing things, feeling a little more normal again, rather than just feeling confined to your home, that's how I felt anyways'.

Enhanced recovery

Involvement in the TDM enhanced the recovery process of clients. Clients benefited from peer support, which ensured the continuity of care after discharge provided through therapeutic relationships between clients and their peer supporters. Some of the participants noted these benefits as follows:

> 'I don't think I could be where I am without peer support. My peer support really listens... probably is one of the best people for this program. My peer really has the heart, and cares about me. The program [TDM] is amazing'.

> 'With everything going on with me, finding somebody else that even comes close to understanding what I'm going through, it's a big deal. . ..'

Help with substituting lost social networks

One of common challenges associated with mental illness is the loss of pre-existing relationships. The loss results from the fact that some clients either quit their jobs or suffer from stigma from their old friends. Through implementing the TDM, clients felt that peer supporters helped them build up new social networks that alleviated negative experiences associated with the loss of friendships. Clients' experience of their loss and ways in which the TDM helped alleviate these experiences were illustrated by the following quotes:

> '. . . you know, I'm off work right now um.. I miss the social aspect of my friends and colleagues at work and I've lost friends due to my illness. They've kind of passed me by and said well, we don't need you anymore so I've lost a few friends um I've made a few friends here, I'm in contact with a couple of the other patients that I met on the inpatient unit which is good'.
>
> 'When I was going through what I was going through, I wish I had somebody that on the outside was able to meet with me and talk with me and go through the same thing that I am, one-on-one. . .. I wish it was there [TDM] a long time ago, but it's nice to see that it's happening now, I really am thrilled that it's happening now'.

Added value of the TDM for community integration

Focus group discussions revealed three client perceptions, which were vital for accepting the TDM and its effectiveness for community integration. Clients believed that the intervention offered suitable friendships, a source of appropriate social connectedness, and helped reduce stigma.

Peer support as a suitable friendship

Interactions between clients and peer supporters participating in the TDM were quickly built and fulfilling due to shared interests. Clients were enthusiastic about having peer supporters with whom they had common interests and experiences of mental illness. One participant reiterated this enthusiasm by the following statement:

> 'We hit it off, like I think just in terms of personality, interests, um background experience, everything, it's a perfect match, so I think that really helped the relationship too because we're just so similar, so it was almost like meeting another best friend'.

The TDM as a source of appropriate social connectedness

Some clients had experienced a distressing loss of social contacts. These clients reported that being connected to peer supporters was appropriate in that their peers were able to better understand their situation compared to any other friend. During a focus group, one client said:

> '. .. your life being completely uprooted, going from working, to all of a sudden being at home, and not having the same supports, it was important to have a brand new support introduced, somebody that can actually understand what you're going through, because I think even, you can have friendships that you've had for years, but they don't necessarily understand mental health'.

Fighting stigma

Some client participants had previously experienced stigma from family relatives as a result of their mental illness. They reported that through education sessions by hospital staff and meeting with peer supporters, clients' relatives changed their attitudes towards mental illness. This is what a participant intimated:

> 'People have to understand that uh, while you may have a psychiatric problem, first of all, it may not be permanent, and second of all, it's not contagious, certainly not over the telephone'.

Other participants expressed satisfaction with the impact of involving family relatives during the TDM implementation. A participant shared:

> 'I'm happy that my family was able to meet with the doctor and the outpatient worker [peer supporter]'

Another participant disclosed:

> 'I actually brought my parents into one of my sessions with my psychologist and the way we sat, it had a huge impact on [attitudes towards the client with mental health illness], and she talked directly to my parents'.

Encountered challenges

Issues with trust

Findings showed that changing hospital staff or peer supporters who had already established relationships with clients may lead to issues with trust. For example, some clients felt disappointed when they had to work with new bridging staff or peer supporters because

they were not familiar with them. Clients exemplified this issue of trust using the following statement:

> 'Have to go through so many people, and when you get used to them, you are getting passed off. Being moved from one person to another'.
> '...and then it's very upsetting for you. Because you don't feel trusted, you feel let down or something'.

Other issues with trust were related to a mismatch between clients and bridging staff or peer supporters. This issue of trust was expressed by one of the clients:

> '...very nice girl...she has nothing in common with me. I realise that she has some frame of reference but I didn't feel comfortable talking to someone who is younger than my own children...'

Peer supporters as intruders

Although client participants were appreciative of the TDM, some were not happy with certain aspects of the intervention. To a certain extent, some clients felt that interactions with peer porters were invasive.

> 'It's very hard, it's very hard people come at you, you need space, you are in here with people you don't know, some people you don't want to be around. So when you get home, you just want some time alone, you know?'
> 'I think that before we are.... discharged that uh... I personally I want to find a doctor I like first of all and I can trust and one that I can form a long term relationship with'.

Issues with communication

Some participants were not happy about the lack of detailed information received on the TDM intervention. Clients felt that health professionals did not actively engage them in communication regarding what the TDM entailed. Clients mentioned that:

> 'They don't inform you of the programs [TDM] you qualify for as an outpatient'.
> 'But as far as the outpatient programs in the hospital that really wasn't explained to me and I didn't really know'.

Initial fears about discharge

During the hospital stay, clients with mental illness may have fears related to how they get settled back into their communities. Clients expressed fears which they anticipated about discharge based on their previous experiences. Clients described the transition from the hospital to the community as a scary process and found going back home would bring discomfort. The client intimated:

> 'A month ago, my life got completely uprooted, and I'm in the hospital now, so you spend a month there, and you kind of get used to that, and then all of a sudden you have to go back to your home.... it's not a comfortable place because you haven't been there for a month and a half'.

Suggestions for improving the TDM

More in-person interactions

Some participants disclosed that they prefer more face-to-face interaction with both staff and peer supports even when they are in the community compared to over-reliance on phone interactions.

> 'It's just awesome seeing his face, so it'd be nice, you know, that's one thing I would improve upon, maybe incorporating more face to face contact vs. phone'.
> 'With the phone is so hit or miss... like you end up playing phone tag, that's what happened to me'.

Formalizing the TDM

Some participants suggested formalizing the TDM so that it becomes a standard programme that can assist both clients and health professionals while discussing discharge planning.

One client advised:

> 'Once you have a plan in place, try and stick to it. Then for patients, I think, following through with the schedule would be helpful. I know people that have a contact every two weeks and they've had that for ten years'.

Raising awareness of resources available in the community

Clients suggested that providing them with information concerning available resources, in the form of brochures and bulletins before discharge would help with community integration.

> ''I get connected with social worker, but, I think that it could be better...more awareness regarding available programs and more information about community resources should be included into discharge planning initiatives'.
> 'I think a lot of patients coming out don't know that they can have access to gymnasiums or swimming pools, and many other public facilities'.

DISCUSSION

This study evaluated clients' perceptions of benefits and potential adjustments to the implementation of TDM; an intervention for community integration of clients who have mental illnesses. The study findings

suggest that TDM supports the transition of clients through a staged continuum. The early stage consists of establishing healing relationships which activate the clients' agency for a safe transition to the community. Next, the established relationships facilitate mental state changes. Furthermore, mental state changes facilitate successful community integration (see Fig. 1).

Agency for a safe transition to the community

Clients benefiting from the TDM implementation felt encouraged and comforted by having peer supporters who easily understand their experiences and share success stories. However, previous research found that it takes up to three months for discharged clients to form a relationship with community providers (Forchuk, Martin, Chan, & Jensen, 2005).

Mental state changes

The study findings highlighted mental state changes that are crucial for safely transitioning from hospital to community. Clients benefiting from the TDM intervention reported experiences of (i) enhanced feelings of confidence and reassurance about the transition from hospital to the community; (ii) reduced loneliness associated with the transition period; and (iii) sense of connectedness after newly formed relationships with bridging healthcare staff and peer supporters. The new relationships may have acted as a substitute for the lost social networks due to mental illness. Given that people with mental illness may experience emotional disturbances threatening their self-esteem and ability to perform in social interactions and building relationships, the clients' experience of connectedness was vital.

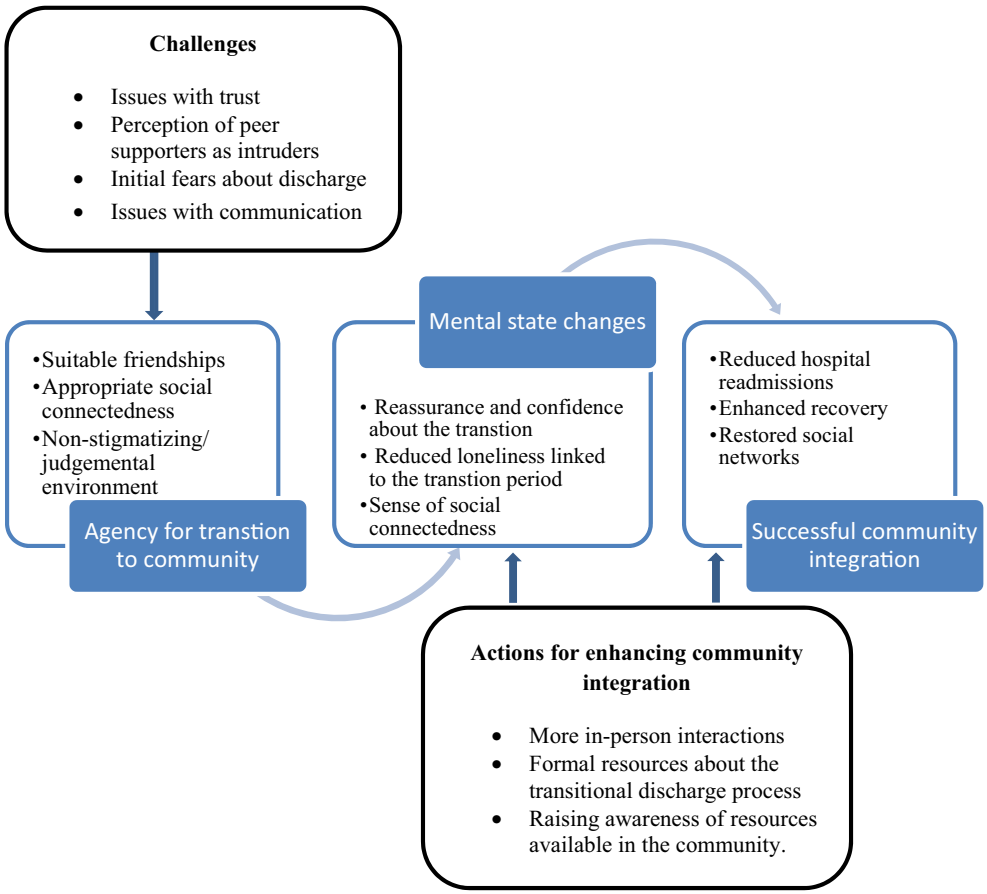

FIG 1 The process of transition of clients from inpatient care to the community.

The consistent presence of peer supporters and openness for sharing personal experiences of mental health illness may reduce self-esteem, feelings of isolation and doubts about one's ability (Chinman, Weingarten, Stayner, & Davidson, 2001). Subsequently, peer supporters ensure emotional and self-esteem support (Hodges, 2007; Wills & Shinar, 2000), which may be necessary for safely navigating through the transition process. Peer supporters' presence and openness for experience sharing may enhance clients' fillings of being appreciated, attended and recognized as a valuable person, a full member of the community (Wills & Shinar, 2000). These reported TDM-driven mental state changes have implications for successful community integration.

Successful community integration

The study findings suggest that a safe transition from inpatient mental health care to the community may be linked to improved clients' community and health outcomes. The study participants reported enhanced recovery, reduced hospital readmissions and restored social networks. These findings are consistent with previous research findings, which demonstrated that TDM enhanced social relationships while reducing the length of hospital stay (Forchuk, *et al*. 2005; Forchuk, *et al*. 2019; Lam, *et al*. 2020). Previous evidence showed that participating in the TDM intervention had reduced symptoms, improved functioning, a better quality of life and fewer hospital readmissions within five months of discharge (Reynolds *et al*. 2004). Additionally, TDM has not only reduced the length of stay, but it has also proven to be cost-effective due to associated savings from the healthcare system spending (Forchuk *et al*. 2019; Lam, *et al*. 2020). The findings in relation to reduction of length of stay and cost savings are consistent with previous research (Lawn, Smith, & Hunter, 2008). To attain a successful community integration for persons with mental illness, the role of peer supporters cannot be overlooked. For instance, recent findings from peer supporters' perspectives of the TDM implementation (Forchuk *et al*. 2020) suggest that Peer supporters play various roles in facilitating clients' transition from hospital to the community. Some of these roles include assisting clients in developing healthy routines, attending regular on-ward and community activities, supporting clients with their appointments and setting goals towards recovery. The involvement of peer supporters in mental healthcare delivery enhances clients' autonomy and gives them hope about their recovery, as well as establishing a safety net whiles helping to reduce hospital readmissions. Nevertheless, peer support implementation may face challenges that may threaten the above-noted benefits of TDM.

Challenges and strategies for improving peer support

The present study findings found that, in some instances, the implementation of peer support may raise issues with trust, communication and peer supporters may also be seen as intruders. Addressing these challenges requires revisiting principles underpinning peer support in mental health. Peer supporters and clients should be informed of principles such as mutual, reciprocal, non-directive, person-centred, and safe interactions between current and ex-service users (Repper *et al*. 2013). In this regard, supervision and training peer supporter in these principles may be of paramount importance in solving challenges identified by the study. The study findings suggest that formalizing and availing the TDM reading resources, facilitating more interactions and matching peer supporters to client's preferences may offer opportunities for successful implementation of peer support intervention. Other strategies include carefully matching clients with their potential peer supporter and maintaining contact with peer supporters/ healthcare providers who have pre-established relationships with the clients.

CONCLUSIONS

This study evaluated clients' perceptions of benefits and potential adjustments involved in implementing the TDM. The study used mixed methods to collect data on the implementation across nine sites over one year. The implementation of TDM intervention led to numerous benefits including enabling clients to get a sense of reassurance about transitioning from hospitals to the community, reducing feelings of isolation, and enhancing continuity of care and recovery during their community stay. Through involvement in the TDM, client–peer supporter interactions became a source of suitable friendships, appropriate social connectedness and reduced stigma towards clients with mental illness.

Relevance for clinical practice

Findings of this study contribute insights that may assist healthcare professionals in early discharge planning towards community integration and strategies for

improving the client transition from hospital to the community. Besides, the findings inform healthcare professionals of potential challenges to community integration, such as issues with trust and communication, as well as clients' perceptions of peer support and their initial fears. In this regard, findings suggest that the training of peer supporters involved in the TDM implementation can emphasize active communication and boundaries of client–peer supporter relationships. Furthermore, findings underscore that potential solutions to challenges associated with implementing the TDM include using more in-person interactions rather than telephone calls. These suggested solutions can adjust future models of transitional discharge from hospital to community.

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